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	17E015	A. BUILDING _____ B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRISELL MEMORIAL HOSPITAL LTCU	330 S VERMONT PO BOX 268 RANSOM, KS 67572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 23 residents. Based on observation and interview the facility failed to provide dining in a dignified manner in 1 of 1 dining rooms for 1 out of 4 days of observation. Findings included: - During initial dining observation on 10/22/12 at 11:59 A.M. administrative staff A stood over one un-sampled resident and fed the resident part of the lunch meal. He/She then walked over to another table in the dining room and stood over another un-sampled resident and began feeding that resident. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported staff should sit and visit with the residents while assisting to feed them. Standing while feeding residents was considered a dignity issue and was not acceptable. The facility did not provide a policy to address	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 dignity in dining. The facility failed to provide a dignified dining environment.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 23 residents. Based on observation, interview and record review the facility failed to develop a comprehensive care plan for 2 of 10 residents sampled for unnecessary medications, #3 for pain and #24 for behaviors.	F 279		

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F 279	Continued From page 2	F 279		

Findings included:

- Resident #3's Physician's Order sheet dated 10/01/12 recorded diagnoses of colon cancer, pain, fibromyalgia and arthritis (diagnoses which could cause musculoskeletal pain). The physician ordered staff to give the resident Tylenol 325 milligrams three times daily for pain and apply a Lidoderm 5% pain patch, one half of a patch to the resident's feet at bed time.

The quarterly Minimum Data Set (MDS) 3.0 dated 8/08/12 documented the resident had pain almost constantly and in the 5 days prior to the assessment the pain limited day to day activities. The resident received scheduled pain medications.

The Care Area Assessment (CAA) for pain dated 2/29/12 documented the resident had chronic pain of the knees and shoulders and received Tylenol three times daily and used a Lidoderm patch (a topical pain medication patch) at night.

The care plan dated 8/16/12 failed to direct staff that the resident had pain almost constantly and did not provide a description of the resident's pain. Staff did not care plan the resident's scheduled Tylenol 325 milligrams three times daily for pain or the Lidoderm patch for pain. The care plan did not direct staff to monitor for the effectiveness of the pain medications or for side effects from the lidoderm patch. The care plan lacked appropriate non-pharmacological pain interventions.

Observation on 10/25/12 at 8:05 A.M. revealed

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F 279	Continued From page 3 the resident sat in the dining room at the table in a wheelchair feeding himself/herself. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported staff did use non-pharmacological pain interventions such as hot packs and the hydrocolator (a device used for pain management), but did not care plan those interventions. The resident started using the Lidoderm patch a long time ago for pain. He/She acknowledged the specific pain medications were not on the care plan and the type and location of pain was not addressed. The facility failed to develop an individualized comprehensive pain care plan for this resident with scheduled pain medications. - Resident #24's Quarterly Minimum Data Set (MDS) 3.0 dated 8/15/12 documented the resident with short and long term memory problems. The resident received an antipsychotic medication within the last 7 days prior to the MDS. The significant change Care Area Assessment (CAA) for antipsychotic use dated 5/22/12 documented the resident received several psychotropic medications and had Alzheimer's disease with increased behaviors. The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (an anti-psychotic medication). The care plan lacked direction for staff to monitor behaviors or	F 279		

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F 279	Continued From page 4 for side effects related to taking Zyprexa. The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia. The current Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts, resistive to cares, physically abusive and restlessness. Observation on 10/25/12 at 8:02 A.M. revealed the resident slept in bed. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the resident started taking Zyprexa on 7/23/12 and staff did not care plan the resident for the Zyprexa after staff completed the last MDS. The facility failed to care plan for behaviors and failed to care plan for scheduled antipsychotic medication for this resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		

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F 280	Continued From page 5 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. The sample included 23 residents. Based on observation, record review, and staff interview, the facility failed to revise the care plan for 1 (#10) resident sampled. Findings included: - The Annual Minimum Data Set (MDS) dated 9/5/12 for resident #10 revealed a Brief Interview for Mental Status (BIMS) score of 8 (moderately impaired cognition); was independent with no set up or physical help from staff for bed mobility, transfer, walk in room/corridor, locomotion on/of unit, and eating; required limited assistance of one person with dressing, toilet use, and personal hygiene; required extensive assistance of one person with bathing; used a walker for mobility device; was occasionally incontinent of urine; frequently incontinent of bowel; was at risk for developing pressure ulcers; used a pressure reducing device for chair/bed, and nutrition or hydration intervention to manage skin problems. The Care Area Assessment (CAA) dated 9/10/12 for Activity of Daily Living (ADL) revealed the	F 280		

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resident was able to be independent with 7 out of 10 areas; required limited assist with dressing, toileting, and personal hygiene; had no falls since May; and depression could affect the resident's ADLs.

The care plan dated 9/13/12 lacked documentation the resident received oxygen therapy.

The Physician's Order Sheet dated 10/1/12 revealed orders for oxygen at 3 liters per nasal cannula PRN.

The Telephone Order dated 10/24/12 revealed orders for oxygen per nasal cannula at 2 to 3 liters when oxygen saturations falls below 90 percent (%) PRN.

Observation on 10/23/12 at 10:10 A.M. revealed the resident sat on a love seat by the nursing station and used oxygen via nasal cannula.

Observation on 10/23/12 at 11:00 A.M. revealed the resident returned to sit on the love seat after ambulating from her/his room with licensed nursing staff H who placed the oxygen cannula back on the resident.

Staff interview on 10/25/12 at 9:42 A.M. with licensed nursing staff D stated nursing staff updated resident care plans with new orders, and significant changes.

Staff interview on 10/25/12 at 10:20 P.M. with administrative nursing staff D stated nursing staff updated care plans quarterly, with new orders, and with significant change.

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F 280	Continued From page 7 The policy and procedure for Resident Care Plan with a revised dated of 10/10 revealed the plan of care was a working tool that provided a profile of the needs of the resident. The facility failed to update/revise the resident's care plan for oxygen use.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 23 residents. Based on observation, interview and record review the facility failed to provide appropriate care and services for 1 of 1 residents sampled for dialysis (#19). Findings included: - Resident #19's Physician's Order Sheet dated 10/1/12 documented a diagnosis of chronic renal failure and ordered a 1500 cubic centimeter per day fluid restriction. The Quarterly Minimum Data Set (MDS) 3.0 dated 8/29/12 recorded the resident with a Brief	F 309		

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interview for Mental Status Score of 15, which indicated the resident had intact cognition. The resident received dialysis (a treatment for kidney disease).

The Care Area Assessment (CAA) for dehydration and fluid maintenance dated 3/14/12 documented the resident at risk for dehydration due to dialysis received twice weekly, a history of diarrhea and he/she used imodium (anti-diarrheal medication). He/She had congestion and staff encouraged him/her to drink out of red glass in the resident's room.

The Care Plan dated 9/6/12 for self care deficit related to chronic renal failure directed staff to cover the intra-jugular site (central blood access device) to prevent it from getting wet. The dialysis unit would do the dressing changes and requested the dialysis center to monitor the resident. Facility staff to send the out- patient communication sheet with the resident to dialysis.

The clinical record contained Outpatient Dialysis Records from 8/17/12 - 10/19/12 with documentation of blood pressures and weights from the dialysis center.

Review of the clinical record revealed a lack of monitoring from the facility after the resident arrived back to the facility following dialysis appointments. No vital signs, nursing assessment or monitoring of the intra-jugular site were documented by the staff in the clinical record.

Review of the Medication and Treatment Administration Records dated 9/1/12 revealed no documented monitoring of the resident's fluid

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F 309	Continued From page 9 restriction or intra-jugular site. Observation on 10/25/12 at 8:00 A.M. revealed the resident sat in his/her room wearing pajamas and watching television. He/She said staff would served breakfast in his/her room. Staff did not need to check him/her after dialysis or keep track of the fluids drank. If he/she needed a nurse, he/she would call. During observation and interview on 10/25/12 at 9:59 A.M. licensed nurse I reported the resident went to dialysis on Tuesdays and Fridays and usually returned to the facility around 4:00 P.M. The facility was in constant communication with the dialysis center. Dialysis did the blood draws, medication changes, all of the maintenance on the dialysis site and did not want the facility to do anything for the resident's dialysis. Staff did cover the dialysis site during showers to keep it dry. Staff did not monitor the resident after dialysis treatments. The resident kept track of his/her own fluid intake and had a red cup in his/her room that he/she used to control his/her own fluids. The facility policy dated 7/14/11 titled Outpatient Dialysis failed to address staff documentation of assessments/monitoring regarding the resident's dialysis. The facility failed to provide adequate monitoring of this resident with an ordered fluid restriction, history of diarrhea and who received dialysis.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 10 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. The sample included 4 residents. Based on observation, record review, and staff interview the facility failed to assist with repositioning of 1 (#10) resident sampled for at risk for pressure ulcers. Findings included: - The Physician's Order Sheet (POS) dated 10/2/12 for resident #10 revealed a diagnosis of dementia (memory problems). The Annual Minimum Data Set (MDS) dated 9/5/12 for resident #10 revealed a Brief Interview for Mental Status (BIMS) score of 8 (moderately impaired cognition); was independent with no set up or physical help from staff for bed mobility, transfer, walk in room/corridor, locomotion on/of unit, and eating; required limited assistance of one person with dressing, toilet use, and personal hygiene; required extensive assistance of one person with bathing; used a walker for mobility device; was occasionally incontinent of urine; frequently incontinent of bowel; was at risk for developing pressure ulcers; used a pressure reducing device for chair/bed, and nutrition or hydration intervention to manage skin problems.	F 314		

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F 314	Continued From page 11 The Care Area Assessment (CAA) dated 9/10/12 for Activity of Daily Living (ADL) revealed the resident was able to be independent with 7 out of 10 areas; required limited assist with dressing, toileting, and personal hygiene. The CAA dated 9/10/12 for Pressure Ulcers revealed the resident did not have any pressure ulcers at this time; had pressure ulcers in the past which healed; sat much of the time; usually laid on her/his back in bed; and the resident weighed 85.5 pounds. The care plan dated 9/13/12 for self-care deficit related to weakness, recorded the resident required limited assist with ADLs; and potential for skin breakdown, and used a pressure relieving mattress on the bed/cushion on the chair. The Braden Scale dated 9/4/12 revealed a score of 21 for low risk for development of pressure ulcers. The Nursing Notes (NN) dated 10/21/12 at 9:25 A.M. revealed the resident's skin was intact. The NN dated 10/22/12 at 9:05 A.M. revealed the resident was incontinent of bowel and bladder twice this morning; the resident still had a productive cough; phlegm clear; lungs had rales in all quadrants; the resident received intravenous (IV) therapy of Lasix. The ADL log for August and September 2012 revealed the resident was continent/incontinent of bowel and bladder; independent with toileting;	F 314		

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F 314	Continued From page 12 used a pressure relieving device in bed; ambulated with a walker independently; and was able to transfer self. The ADL log for October 2012 revealed the resident was both continent/incontinent of bowel and bladder; used a pressure reducing device while in bed/couch; and self transfered with the assistance of one. Observation on 10/23/12 at 10:10 A.M. revealed the resident sat on a couch seat; no pressure reducing cushion present/used. Observation on 10/23/12 at 10:38 A.M. revealed the resident ambulated in the hallway to her/his room with licensed nursing staff H and used a front wheel walker with stand by assist. Observation on 10/23/12 at 11:00 A.M. revealed the resident returned to the couch after he/she ambulated from her/his room, and licensed nursing staff H did not place the pressure reducing cushion on the couch. Observation on 10/23/12 at 12:30 P.M. revealed the resident slept on the couch at the nursing station; and there was no pressure reducing cushion in place. At 12:45 P.M. revealed the resident slept with her/his head bent to the left and resting on left arm of the couch; a chair cushion was at her/his back; and there was no pressure reducing cushion on seat. At 1:00 P.M. revealed the resident slept with her/his head bent to the left and resting on left arm of the couch; and no pressure reducing cushion was on the seat.	F 314		

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F 314	Continued From page 13 At 1:30 P.M. revealed direct care staff P awakened the resident with concerns his/her eye glasses could get bent; staff did not encourage the resident to toilet; and no pressure cushion on the seat. At 1:45 P.M. revealed the resident slept with her/his head bent to the left and resident on the left arm of the couch; licensed nursing staff H wakened the resident to give her/him medication; did not encourage the resident to toilet;and no pressure cushion on the seat. At 2:00 P.M. revealed the resident slept on the couch; head/neck bent to the left and her/his head rested on the left arm of the couch;and no pressure cushion in use. At 2:15 P.M. revealed the resident slept on the couch; head/neck bent to the left and her/his head rested on the left arm of the couch; and no pressure cushion in use; administrative staff A removed the resident's eye glasses. At 2:30 P.M. revealed the resident slept on the couch; head/neck bent to the left and her/his head rested on the left arm of the couch; and no pressure cushion in use; direct care staff O wakened the resident and offered him/her a supplement and did not encourage toileting. At 3:00 P.M. the resident slept on the couch; head/neck bent to the left and her/his head rested on the left arm of the couch; and no pressure cushion in use. At 3:05 P.M. direct care staff P awakened the resident; repositioned her/his upper body; encouraged the resident to stand up and placed a pressure reducing cushion for the resident to sit on; and encouraged the resident to drink her/his supplement. At 3:15 P.M. the resident was awake and sat on the couch and on the pressure reducing cushion.	F 314		

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At 3:30 P.M. the resident was awake and sat on the couch and pressure reducing cushion.
At 3:45 P.M. the resident got up from the couch on her/his own; removed her/his oxygen cannula; used her/his walker and slowly ambulated down the hallway into the bathroom and voided; licensed nursing staff I went into the bathroom, and provided pericare; dark pink area noted below the coccyx area; applied barrier cream; licensed nursing staff I stated the resident's briefs were wet with urine; the resident had chronic diarrhea and received Imodium.

Staff interview on 10/25/12 at 9:42 A.M. with licensed nursing staff I stated the resident liked to sit on the couch; got up on her/his own; used a cushion on the couch to prevent pressure ulcers; applied a barrier cream three times daily and PRN; skin checked with ADL and when staff applied cream; and it was her/his expectation staff informed her/him of any opening on the skin.

Staff interview on 10/25/12 at 10:09 A.M. with direct care staff Q stated since the resident was sick, staff tried to toilet her/him every two hours; before getting sick, the resident went by her/himself; repositioned every two hours; he/she used to come into the dining room to sit but did not do that since she/he got sick; staff applied barrier cream; staff checked skin over when in the bath tub and with toileting; she/he would inform the nurse if she/he noted an open area; and was not often incontinent very often.

Staff interview on 10/25/12 at 10:20 P.M. with administrative nursing staff D stated the resident was occasionally incontinent and would let staff know when she/he needed to go to the restroom

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F 314	Continued From page 15 and was not on a toileting program; used a barrier cream/pressure reducing mattress; and did not like to sit on the pressure reducing pad/cushion and currently used a pillow to sit on. The policy and procedure with the revised dated 4/09 for Prevention/Treatment of Patient with Pressure Ulcers revealed preventive measures would be implemented as a resident was identified as at risk; interventions could include application of pressure reduction devices, keep skin clean and dry; and encourage ambulation/activity. The facility failed to encourage or assist with repositioning for this resident at risk for pressure ulcers.	F 314		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 16 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample was 23 residents. Based on observation, record review, and staff interview, the facility failed to identify medication irregularities for 10 (#12, 25, 23, 15, 21, 4, 2, 24, 3, and #30) of 10 residents sampled for medication review. Findings included: - Resident #23 significant change Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded a Brief Interview for Mental Status (BIMS) score of 3, severely impaired. The resident was independent with Activities of Daily Living (ADL), and rejection of care occurred 1 to 3 days during assessment period. Staff administered antianxiety, antidepressant, and diuretic medications to the resident. The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident. During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went	F 329		

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online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident.
The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.
The facility failed to monitor medication side effects for this resident.

- Resident #12 Annual Minimum Data Set (MDS) 3.0 dated 8/8/12 recorded short and long term memory problems, knew staff names and faces, and had moderately impaired decision making cognitive skills. Staff administered antianxiety and antidepressant medications to the resident.

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F 329	Continued From page 18 The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident. During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary. The facility failed to monitor medication side effects for this resident.	F 329		

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- Resident #25 quarterly Minimum Data Set (MDS) 3.0 dated 10/17/12 recorded a Brief Interview for Mental Status (BIMS) score of 8, which indicated mildly impaired cognition. The resident required supervision and setup with dressing and was independent with all other areas of Activities of Daily Living (ADL). Staff administered antianxiety, antidepressant, anticoagulant, and diuretic medications to the resident.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident.
The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up

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medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.
The facility failed to monitor medication side effects for this resident.

- Resident #2's significant change Minimum Data Set (MDS) 3.0 dated 7/18/12 recorded the resident as severely cognitively impaired. The resident required total staff assistance for transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing, and required extensive staff assistance for bed mobility and eating. Staff administered insulin, antipsychotic and antidepressant medications to the resident.
The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.
During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H

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acknowledged the facility did not have individualized medication side effects listed for the resident.
The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.
The facility failed to monitor medication side effects for this resident.

- Resident #4's quarterly Minimum Data Set (MDS) 3.0 dated 8/15/12 recorded the Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition. The MDS recorded the resident required total staff assistance for locomotion on and off the unit and personal hygiene, and extensive staff assistance for bed mobility, transfers, dressing and toilet use. Staff gave the resident insulin, antidepressant, anticoagulant (prevents blood clots) and diuretic (increased fluid release) medications.
The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.
During an interview on 10/24/12 at 9:58 A.M.,

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F 329	Continued From page 22 licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary. The facility failed to monitor medication side effects for this resident. - Resident #3's Physician's Order sheet dated 10/01/12 recorded diagnoses of colon cancer,	F 329		

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pain, fibromyalgia and arthritis (diseases which effect the musculoskeletal system and could cause pain). The physician ordered staff to give the resident Tylenol 325 milligrams three times daily for pain and apply a Lidoderm 5% pain patch, one half of a patch to the resident's feet at bed time. The physician also ordered staff to administer Exelon (for cognition), Miralax (for bowel), Prilosec (for ulcer treatment), Allopurinol (for gout treatment), Metoprolol (for blood pressure), Novolog and Lantus insulins to the resident.

The quarterly Minimum Data Set (MDS) 3.0 dated 8/08/12 documented the resident had pain almost constantly and in the 5 days prior to the assessment the pain limited day to day activities. The resident took scheduled pain medications.

The Care Area Assessment (CAA) for pain dated 2/29/12 documented the resident had chronic pain of the knees and shoulders and took Tylenol three times daily and used a Lidoderm patch (a topical pain medication patch) at night.

The care plan dated 8/16/12 failed to direct staff that the resident had pain almost constantly and did not provide a description of the resident's pain. Staff did not care plan the resident's scheduled Tylenol 325 milligrams three times daily for pain or the Lidoderm patch for pain. The care plan did not direct staff to monitor for the effectiveness of the pain medications. The care plan lacked appropriate non-pharmacological pain interventions. Facility staff failed to included side effects for staff to monitor related to the use of Exelon, Miralax, Prilosec, Allopurinol, Metoprolol and insulins were not recorded in the

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F 329	Continued From page 24 clinical record. Observation on 10/25/12 at 8:05 A.M. revealed the resident sat in the dining room at the table in a wheelchair feeding himself/herself. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported staff did use non-pharmacological pain interventions such as hot packs and the hydrocolator (a device used for pain management), but did not care plan those interventions. The resident started using the lidoderm patch a long time ago for pain. He/She acknowledged the specific pain medications were not on the care plan and the type and location of pain was not addressed. Staff had a phone application which they could use to look up potential side effects of medications or there was a drug reference book located at the nurse's station. Staff did not care plan specific medications and side effects for staff to monitor for with individual residents. The facility failed to monitor this resident for medication side effects. - Resident #24's Quarterly Minimum Data Set (MDS) 3.0 dated 8/15/12 documented the resident with short and long term memory problems. The resident received an antipsychotic medication within the last 7 days prior to the MDS. The significant change Care Area Assessment (CAA) for antipsychotic use dated 5/22/12 documented the resident received several	F 329		

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psychotropic medications and had Alzheimer's disease (a disease that effects cognition) with increased behaviors.

The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (a medication used to treat psychosis). The care plan lacked direction for staff to monitor behaviors for side effects related to taking Zyprexa. The care plan did not direct staff on the Black Box Warning (BBW) for Zyprexa.

The United States (US) Food and Drug Administration (FDA) issued BBW for Zyprexa indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death.

The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia.

Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts, resistive to cares, physically abusive and restlessness.

Observation on 10/25/12 at 8:02 A.M. revealed the resident slept in bed.

During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the resident started taking Zyprexa on 7/23/12 and staff did not care plan the resident for the Zyprexa after staff completed the last MDS. He/She acknowledged the care plan failed to direct staff to monitor the resident's behaviors or to monitor

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F 329	Continued From page 26 for the Black Box Warning side effects. The facility failed to monitor this resident receiving an antipsychotic medication with a Black Box Warning (a warning to the hazardous conditions related to the use of the medication). - Resident #30's Physician's Order Sheet dated 10/01/12 ordered staff to administer Meclizine 25 milligrams three times daily for dizziness and Clonazepam 0.5 milligrams three times daily for anxiety. The quarterly Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded the resident received antipsychotic and antianxiety medication 7 days each out of the 7 days prior to the assessment. The admission Care Area Assessment (CAA) for psychotropic medications dated 6/26/12 recorded the resident recently returned from a psychiatric hospital stay prior to admission and received several psychotropic medications. The resident received Lexapro and Clonazepam for several months. The care plan dated 9/20/12 for psychosocial alteration directed staff to administer Clonazepam and monitor for side effects of the medications and perform the behavior management plan, but did not list what the potential side effects of the medication were that staff should monitor for. The comprehensive care plan did not direct staff that the resident took scheduled Meclizine three times daily and did not direct the staff on what side effects to monitor for.	F 329		

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The October 2012 Behavior Sheet showed staff monitored behaviors and did a psychotropic medication assessment, but failed to indicate what specific behaviors staff were to monitor for which medications.

Observation on 10/25/12 at 8:03 A.M. revealed the resident opened the door to his/her room and stood in the doorway.

During interview on 10/25/12 at 10:37 A.M. administrative nurse D acknowledged the side effects for the Clonazepam and Meclazine were not care planned. Staff used the application on their phones or the drug book at the nurse's station to see what side effects to monitor for specific medications.

The facility failed to monitor this resident for adverse side effects to medications.

- The Physician's Order Sheet (POS) dated 10/1/12 for resident #21 revealed diagnoses of dementia (memory problems), multifactorial Alzheimer's type (memory problems); ischemic cerebrovascular accident (stroke); diabetes type I (blood sugar problems); atherosclerotic coronary artery disease (build up of deposits in blood vessels); hypertension (high blood pressure); osteoarthritis (sore bone joints), and hyperlipidemia (high fat levels in the blood).

The Quarterly Minimum Data Set (MDS) dated 8/8/12 revealed the resident had long/short term memory problems; was able to recall staff names/faces; had moderately impaired cognitive

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skills for daily decision making; scored 3 (mild depression) for mood; and received antipsychotic/antidepressant medications.

The clinical record lacked evidence of medication side effects for all of the medications staff gave the resident.

Staff interview on 10/23/12 at 9:00 A.M. with licensed nursing staff H stated she/he obtained the medication side effects from a nursing drug book located at the nursing station, on her/his phone, or could be looked up on the computer.

Staff interview on 10/23/12 at 9:05 A.M. with direct care staff R stated staff could obtain medication side effects from the nurse or the drug book located at the nursing station.

The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.

The facility failed to monitor medication side

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F 329	Continued From page 29 effects for this resident. - The Physician's Order Sheet (POS) dated 10/1/12 for resident #15 revealed diagnoses of hypertension (high blood pressure), hypocalcemia (low calcium in the blood), hyperlipidemia (high fat in the blood), iron deficiency anemia (low iron in the blood), depression (mood disorder), leukocytosis (high white blood cells in the blood), dementia (memory problems), sundowners (mood disorder), and constipation (irregular bowel movement. The Significant Change Minimum Data Set (MDS) dated 9/26/12 revealed a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment); and received antipsychotic and antidepressant medications. The clinical record lacked evidence of medication side effects for all of the medications staff gave the resident. Staff interview on 10/23/12 at 9:00 A.M. with licensed nursing staff H stated she/he obtained the medication side effects from a nursing drug book located at the nursing station, on her/his phone, or could be looked up on the computer. Staff interview on 10/23/12 at 9:05 A.M. with direct care staff R stated staff could obtain medication side effects from the nurse or the drug book located at the nursing station. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff	F 329		

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F 329	Continued From page 30 to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary. The facility failed to monitor medication side effects for this resident.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. Based on observation, record review, and staff interview the facility failed to store/label open food items in the kitchen; failed to maintain clean	F 371		

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kitchen equipment; and failed to wash hands while assisting residents in the main dining room for one of four days on site of the survey.

Findings included:

- Observation on 10/22/12 at 8:00 A.M. revealed opened undated/unlabeled food in a cabinet which contained a 2 pound (#) bag of Cheerios, 2# bag of Corn Flakes, 2# bag of Rice Crispy cereal; 2 small dessert cups of chocolate pudding not covered or labeled in the kitchen refrigerator; open unlabeled bag of chicken patties and chicken pieces, and hamburger buns.

Staff interview on 10/22/12 at 10:00 A.M. with Dietary Staff DD stated staff were to label food with a date when opened.

The Policy and Procedure dated June 1999 for Procedure for Left Over Foods revealed if there were left over foods they were stored in containers with lids, labeled, dated and stored in the refrigerator.

Observation on 10/22/12 at 8:05 A.M. revealed a three spout milk dispenser dripped milk under one spout onto the counter; noted under the other two spouts had thick milk build up; the large mixer cover had brown splatter on the white plastic cover; and the blender's base had food debris on it.

Staff interview on 10/23/12 at 11:35 A.M. with Dietary Staff DD stated kitchen staff were responsible for cleaning the kitchen equipment; dietary employees had daily assignments and she/he followed up that staff completed the

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cleaning assignments.

The Policy and Procedure undated/untitled revealed a daily and monthly kitchen cleaning schedule.

Observation on 10/22/12 at 11:37 A.M. revealed direct care staff P touched an un-sampled resident, who she/he fed, on the shoulder and then pushed her/his hair back off her/his forehead. She/he then moved over to the another resident at the table and picked up her/his glasses by the rim. She/he then touched the drinking end of the a straw and ran her/his fingers up/down the end to straighten it out and then gave the resident a drink through the straw. At 11:54 A.M. she/he then brought a loaf of bread into the dining room and held it with her/his bare hands, and cut the bread, then buttered it, and handed it to several different residents.

Staff interview on 10/25/12 at 10:37 A.M. with administrative nursing staff D stated staff did not need to wash hands between feeding residents, but should not serve bread with bare hands, touch the drinking ends of the straw or touch the rim of the drinking glass.

Observation on 10/22/12 at 11:43 A.M. revealed direct care staff O removed the audio ear piece from her/his left ear examined it and replaced the ear piece back into her/his left ear twice; obtained a cup of coffee for a resident, and did not wash her/his hands.

Staff interview on 10/22/12 at 3:40 P.M. with direct care staff O stated staff should wash hands when going into and leaving the dining room; and

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F 371	Continued From page 33 after touching the ear piece on the head sets worn by staff before they assist residents with their meals. Staff interview on 10/25/12 at 11:30 A.M. with Administrative Nursing Staff D stated it was her/his expectation that staff wash their hands after taking out and re-inserting the ear piece of their head sets before assisting residents with meal. The policy and procedure for Handwashing with a revised date of 9/07 revealed staff should wash hands before direct resident contact; after contact with a resident's intact skin, and after contact with inanimate objects in the immediate vicinity of the resident. The facility failed to label open foods; failed to keep kitchen equipment clean; and failed to assist residents with meals in a sanitary manner.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		

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F 425	Continued From page 34 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents and the sample included 23 residents. Based on observation, record review and interview, the facility failed to obtain blood pressure parameters for 7 (#23,#25,#3,#30,#15,#21,#2) of 10 residents reviewed for medications. - Resident #23's significant change Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded a Brief Interview for Mental Status (BIMS) score of 3, severely impaired. The resident was independent with Activities of Daily Living (ADL), and rejection of care occurred 1 to 3 days during the assessment period. Staff administered antianxiety, antidepressant, and diuretic medications to the resident. The Medication Administration Record (MAR) dated 10/1/12 recorded the physician's order for Atenolol (high blood pressure medication) every day for hypertension (high blood pressure). The MAR lacked any blood pressure parameters for staff to hold the medication. The Standing Orders dated 4/9/12 lacked any blood pressure medication parameters.	F 425		

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During an interview on 10/24/12 at 9:34 A.M., licensed nursing staff H stated staff obtained all resident blood pressures every week unless the resident's doctor ordered otherwise. When the resident was on a medication for blood pressure, licensed staff used their own judgment if the blood pressure was too low to give or hold a medication, and if staff held a medication they were to document and monitor the resident's blood pressure and notify the physician. Licensed nursing staff H stated the facility did not have standing physician's orders of parameters for when to hold a blood pressure medication or for other medications that may affect a resident's blood pressure.

The facility lacked a policy for blood pressure medication parameters.

The facility failed to provide parameters for this resident's blood pressure medication.

- Resident #25's quarterly Minimum Data Set (MDS) 3.0 dated 10/17/12 recorded a Brief Interview for Mental Status (BIMS) score of 8, mildly impaired. The resident required supervision and setup with dressing and was independent with all other areas of Activities of Daily Living (ADL). Staff administered antianxiety, antidepressant, anticoagulant, and diuretic medications to the resident.

The Medication Administration Record (MAR) dated 10/1/12 recorded the physician's order for Lisinopril, Metoprolol, and Norvasc (high blood pressure medications) every day for hypertension (high blood pressure). The MAR lacked any blood

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pressure parameters for staff to hold the medication.

The Standing Orders dated 4/9/12 lacked any blood pressure medication parameters.

During an interview on 10/24/12 at 9:34 A.M., licensed nursing staff H stated staff obtained all residents blood pressures every week unless the resident's doctor ordered otherwise. When the resident was on a medication for blood pressure, licensed staff used their own judgment if the blood pressure was too low to give or hold a medication, and if staff held a medication they were to document and monitor the resident's blood pressure and notify the physician. Licensed nursing staff H stated the facility did not have standing physician's orders of parameters for when to hold a blood pressure medication or for other medications that may affect a resident's blood pressure.

The facility lacked a policy for blood pressure medication parameters.

The facility failed to provide parameters for this resident's blood pressure medication.

- Resident #3's Physician's Order sheet dated 10/01/12 recorded a diagnosis of hypertension (high blood pressure). The physician ordered staff to give the resident Metoprolol (a blood pressure medication) 50 milligrams twice daily for tachypnea (rapid breathing) and monitor the resident's blood pressure weekly. The clinical record lacked blood pressure parameters for staff

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F 425	Continued From page 37 to follow when they administered anti-hypertensive medications. The care plan dated 8/16/12 failed to direct staff that the resident took Metoprolol which effected the resident's blood pressure and needed monitoring weekly. The care plan failed to provide staff with parameters for this resident's Metoprolol. Observation on 10/25/12 at 8:05 A.M. revealed the resident sat in the dining room at the table in a wheelchair feeding himself/herself. During an interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the facility did not have a policy which directed staff on blood pressure parameters and when to hold medications which affected blood pressure. Some residents had specific parameters ordered by the physician, but not this resident. The facility failed to provide blood pressure parameters for this resident. - Resident #30's Physician's Order Sheet dated 10/01/12 recorded a diagnosis of hypertension (high blood pressure) and ordered Nifedipine (a medication that effected blood pressure) 60 milligrams daily for high blood pressure and to check the resident's blood pressure weekly. The physician did not list blood pressure parameters. The quarterly Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded the resident received an	F 425		

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F 425	Continued From page 38 antipsychotic and antianxiety medication 7 days each out of the 7 days prior to the assessment. The comprehensive care plan dated 9/20/12 did not direct staff on when to hold the resident's blood pressure medication, when to call the doctor, and lacked blood pressure parameters. Observation on 10/25/12 at 8:03 A.M. revealed the resident opened the door to his/her room and stood in the doorway. During interview on 10/25/12 at 10:37 A.M. administrative nurse D acknowledged the clinical record lacked blood pressure parameters and the facility did not have a policy to direct staff on when to hold blood pressure medications or call the physician. The facility failed to provide blood pressure parameters for this resident taking blood pressure medication. - The Physician's Order Sheet (POS) dated 10/1/12 for resident #15 revealed a diagnosis of hypertension (HTN; high blood pressure). The Significant Change Minimum Data Set (MDS) dated 9/26/12 revealed a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment). The POS dated 10/1/12 revealed orders for Metoprolol 25 milligram (mg) by mouth (PO) daily for HTN; Isosorbide Mononitrate 15 mg PO daily at night for HTN; and weekly blood pressure.	F 425		

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F 425	Continued From page 39 Staff interview on 10/24/12 at 9:34 A.M. with licensed nursing staff H stated staff obtained all resident blood pressures every week unless the resident's doctor ordered otherwise; when the resident was on a medication for blood pressure, licensed staff used their own judgement if the blood pressure was too low to give or hold a medication, and if staff held a medication they were to document and monitor the resident's blood pressure and notify the physician; the facility did not have standing physician's orders of parameters which directed staff when to hold a blood pressure medication or for other medications that may affect a resident's blood pressure. Staff interview on 10/25/12 at 9:54 A.M. with licensed nursing staff I stated the charge nurse checked the blood pressure weekly; the certified medication aide (CMA) checked blood pressure (BP) in the evening; the CMA would inform the nurse for readings of 90 and above diastolic. The facility lacked a policy and procedure for blood pressure medication parameters. The facility failed to provide parameters for this resident's blood pressure medications. - The Physician's Order Sheet (POS) dated 10/1/12 for resident #21 revealed a diagnosis of hypertension (HTN; high blood pressure). The Quarterly Minimum Data Set (MDS) dated 8/8/12 revealed the resident had long/short term	F 425		

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memory problems; was able to recall staff names/faces; and had moderately impaired cognitive skills for daily decision making.

The POS dated 10/1/12 revealed orders for Cozaar 100 milligrams (mg) by mouth (PO) daily for HTN; Amlodipine 10 mg PO daily for HTN; Atenolol 100 mg PO daily for HTN; and weekly blood pressure.

Staff interview on 10/24/12 at 9:34 A.M. with licensed nursing staff H stated staff obtained all resident blood pressures every week unless the resident's doctor ordered otherwise; when the resident was on a medication for blood pressure, licensed staff used their own judgement if the blood pressure was too low to give or hold a medication, and if staff held a medication they were to document and monitor the resident's blood pressure and notify the physician; the facility did not have standing physician's orders of parameters for when to hold a blood pressure medication or for other medications that may affect a resident's blood pressure.

Staff interview on 10/25/12 at 9:54 A.M. with licensed nursing staff I stated the charge nurse checked the blood pressure weekly; the certified medication aide (CMA) checked blood pressure (BP) in the evening; the CMA would inform the nurse for readings of 90 and above diastolic.

The facility lacked a policy and procedure for blood pressure medication parameters.

The facility failed to provide parameters for this resident's blood pressure medications.

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- Resident #2's significant change Minimum Data Set (MDS) 3.0 dated 7/18/12 recorded the resident as severely cognitively impaired. The resident required total staff assistance for transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing, and required extensive staff assistance for bed mobility and eating. Staff administered insulin, antipsychotic and antidepressant medications to the resident.

The Medication Administration Record (MAR) dated 10/1/12 recorded the physician's order for Lotrel (high blood pressure medication) every day for hypertension (high blood pressure). The MAR lacked any blood pressure parameters for staff to hold the medication.

The Standing Orders dated 4/9/12 lacked any blood pressure medication parameters.

During an interview on 10/24/12 at 9:34 A.M., licensed nursing staff H stated staff obtained all resident's blood pressures every week unless the resident's doctor ordered otherwise. When the resident was on a medication for blood pressure licensed staff used their own judgment if the blood pressure was too low to give or hold a medication, and if staff held a medication they were to document and monitor the resident's blood pressure and notify the physician. Licensed nursing staff H stated the facility did not have standing physician's orders of parameters for when to hold a blood pressure medication or for other medications that may affect a resident's blood pressure.

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F 425	Continued From page 42 The facility lacked a policy for blood pressure medication parameters. The facility failed to provide parameters for this resident's blood pressure medication.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample for medication review included 10 residents. Based on observation, record review, and staff interview, the facility consultant GG failed to report medication regime irregularities for 10 (#12, 25, 23, 15, 21, 4, 2, 24, 3, and #30) residents of the sample. Findings included: - Resident #23's significant change Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded a Brief Interview for Mental Status (BIMS) score of 3, severely impaired. The resident was independent with Activities of Daily Living (ADL),	F 428		

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and rejection of care occurred 1 to 3 days during the assessment period. Staff administered antianxiety, antidepressant, and diuretic medications to the resident.

The clinical record lacked evidence of medication side effects identified/monitored for any of the medications staff gave the resident.

The pharmacist's Drug Regimen Reviews dated 7/26/12, 8/25/12, 9/27/12, and 10/18/12 failed to identify the lack of medication side effects for this resident.

During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident.

Unable to contact pharmacy consultant GG for interview on 10/29/12 at 1:55 P.M.

The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff

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to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.

The consultant pharmacy staff GG failed to identify the lack of side effects to monitor for this resident's medication.

- Resident #12's Annual Minimum Data Set (MDS) 3.0 dated 8/8/12 recorded short and long term memory problems, knew staff names and faces, and had moderately impaired decision making cognitive skills. Staff administered antianxiety and antidepressant medications to the resident.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The pharmacist's Drug Regimen Reviews dated 7/19/12, 8/30/12, 9/20/12, and 10/18/12 failed to identify the lack of medication side effects for

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F 428	Continued From page 45 staff to refer to. During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident. Unable to contact pharmacy consultant GG for interview on 10/29/12 at 1:55 P.M. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the	F 428		

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summary.

The consultant pharmacy staff GG failed to identify the lack of side effects to monitor for this resident's medications.

- Resident #25's quarterly Minimum Data Set (MDS) 3.0 dated 10/17/12 recorded a Brief Interview for Mental Status (BIMS) score of 8, mildly impaired. The resident required supervision and setup with dressing and was independent with all other areas of Activities of Daily Living (ADL). Staff administered antianxiety, antidepressant, anticoagulant, and diuretic medications to the resident.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The pharmacist's Drug Regimen Reviews dated 7/19/12, 8/23/12, 9/27/12, and 10/18/12 failed to identify the lack of medication side effects for staff to refer to.

During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect

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information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident.

Unable to contact pharmacy consultant GG for interview on 10/29/12 at 1:55 P.M.

The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.

The consultant pharmacy staff GG failed to identify the lack of side effects to monitor for this resident's medications.

- Resident #2's significant change Minimum Data Set (MDS) 3.0 dated 7/18/12 recorded the resident as severely cognitively impaired. The resident required total staff assistance for

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transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing, and required extensive staff assistance for bed mobility and eating. Staff administered insulin, antipsychotic and antidepressant medications to the resident.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The pharmacist's Drug Regimen Reviews dated 10/18/12, 9/27/12, 8/23/12 and 7/26/12 failed to identify the lack of medication side effects for staff to refer to.

During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual; the nurse assessed the resident before staff gave the medication.

Unable to contact pharmacy consultant GG for interview on 10/29/12 at 1:55 P.M.

The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage

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application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.

The consultant pharmacy staff failed to identify that the facility did not monitor side effects for this resident's medications.

- Resident #4's quarterly Minimum Data Set (MDS) 3.0 dated 8/15/12 recorded the Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition. The MDS recorded the resident required total staff assistance for locomotion on and off the unit and personal hygiene, and extensive staff assistance for bed mobility, transfers, dressing and toilet use. Staff gave the resident insulin, antidepressant, anticoagulant (prevents blood clots) and diuretic (increased fluid release) medications.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The pharmacist's Drug Regimen Reviews dated 10/18/12, 9/27/12, 8/23/12 and 7/26/12 failed to identify the lack of medication side effects for this resident.

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F 428	Continued From page 50 During an interview on 10/24/12 at 9:58 A.M., licensed nursing staff H stated when the nurses had questions or concerns about medication side effects they consulted the medication book, went online to Lippincott's Nursing Drug Advisor, or talked the situation over with other nurses. Licensed nursing staff H also consulted his/her telephone application for medication side effect information. Licensed nursing staff H stated when the resident acted or seemed different than usual the nurse assessed the resident before staff gave the medication. Licensed nursing staff H acknowledged the facility did not have individualized medication side effects listed for the resident. Attempted to call but unable to reach pharmacy consultant GG for interview on 10/29/12 at 1:55 P.M. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary.	F 428		

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The consultant pharmacy staff failed to identify the lack of side effects to monitor for this resident's medications.

- Resident #3's Physician's Order sheet dated 10/01/12 recorded diagnoses of colon cancer, pain, fibromyalgia and arthritis (conditions which effect the musculoskeletal system with a potential to cause pain). The physician ordered staff to give the resident Tylenol 325 milligrams three times daily for pain and apply a Lidoderm 5% pain patch, one half of a patch to the resident's feet at bed time. The physician also ordered staff to administer Exelon (for cognition), Miralax (for bowels), Prilosec (for digestion), Allopurinol (treatment for uric acid levels), Metoprolol (for high blood pressure), Novolog and Lantus insulins (for blood sugars) to the resident.

The quarterly Minimum Data Set (MDS) 3.0 dated 8/08/12 documented the resident had pain almost constantly and in the 5 days prior to the assessment the pain limited day to day activities. The resident received scheduled pain medications.

The Care Area Assessment (CAA) for pain dated 2/29/12 documented the resident had chronic pain of the knees and shoulders, received Tylenol three times daily and used a lidoderm patch (a topical pain medication patch) at night.

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F 428	Continued From page 52 The care plan dated 8/16/12 failed to direct staff that the resident had pain almost constantly and did not provide a description of the resident's pain. Staff did not care plan the resident's scheduled Tylenol 325 milligrams three times daily for pain or the lidoderm patch for pain. The care plan did not direct staff to monitor for the effectiveness of the pain medications. The care plan lacked appropriate non-pharmacological pain interventions. Staff failed to include side effects for staff to monitor as related to the Exelon, Miralax, Prilosec, Allopurinol, Metoprolol and insulins. The clinical record contained monthly medication regimen reviews from 1/26/12-10/18/12 which failed to identify the need for the care plan to direct on the use of pain medications, for side effect monitoring for Lidoderm patches, and did not direct staff on what side effects staff to monitor for related to the Exelon, Miralax, Prilosec, Allopurinol, Metoprolol, Novolog and Lantus. Observation on 10/25/12 at 8:05 A.M. revealed the resident sat in the dining room at the table in a wheelchair feeding himself/herself. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the medication regimen review from the pharmacy consultant did not include a review of the resident's care plan and did not identify the need for staff to list specific side effects for medications for staff to monitor.	F 428		

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F 428	Continued From page 53 The pharmacy consultant GG failed to identify the facility's lack of side effect monitoring for this resident. - Resident #24's Quarterly Minimum Data Set (MDS) 3.0 dated 8/15/12 documented the resident with short and long term memory problems. The resident received an antipsychotic medication within the last 7 days prior to the MDS. The significant change Care Area Assessment (CAA) for antipsychotic use dated 5/22/12 documented the resident received several psychotropic medications and had Alzheimer's disease (a disease effecting cognition) with increased behaviors. The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident took Zyprexa. The care plan lacked direction for staff to monitor behaviors or for side effects related to taking Zyprexa. The care plan did not direct staff on the (BBW) Black Box Warning (warning of hazardous conditions related to the use of a drug) for Zyprexa. The United States (US) Food and Drug Administration (FDA) issued BBW for Zyprexa	F 428		

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F 428	Continued From page 54 indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death. The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia. The current Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts, resistive to cares, physically abusive and restlessness. The clinical record contained monthly medication regimen reviews from 1/26/12-10/25/12 which failed to identify the need for specific side effect monitoring and failed to identify the Black Box Warning side effects for Zyprexa. Observation on 10/25/12 at 8:02 A.M. revealed the resident slept in bed. During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the resident started taking Zyprexa on 7/23/12 and staff did not care plan the resident for the Zyprexa after the last MDS was completed. He/She acknowledged the care plan failed to direct staff to monitor the resident's behaviors or for the Black Box Warning. The consultant pharmacy staff GG failed to	F 428		

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F 428	Continued From page 55 identify the facility's lack of monitoring for this resident taking antipsychotic medication with a Black Box Warning. - Resident #30's Physician's Order Sheet dated 10/01/12 recorded staff to administer Meclizine 25 milligrams three times daily for dizziness and Clonazepam 0.5 milligrams three times daily for anxiety. The quarterly Minimum Data Set (MDS) 3.0 dated 9/12/12 recorded the resident received an antipsychotic and antianxiety medication 7 days each out of the 7 days prior to the assessment. The admission Care Area Assessment (CAA) for psychotropic medications dated 6/26/12 recorded the resident recently returned from a psychiatric hospital stay prior to admission and took several psychotropic medications. The resident had diagnoses of anxiety and depression. The resident received Lexapro and Clonazepam for several months. The care plan dated 9/20/12 for psychosocial alteration directed staff to administer Clonazepam and monitor for side effects of the medications and perform the behavior management plan, but did not list the potential side effects of the medication staff should monitor for. The comprehensive care plan did not direct staff that the resident received scheduled Meclizine three	F 428		

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F 428	Continued From page 56 times daily and did not direct the staff on what side effects to monitor for. The current Behavior Management Plan showed monitoring of behaviors and then a psychotropic medication assessment, but did not indicate which behaviors were specific for which medications. Review of the last monthly medication regimen review by the consultant pharmacy dated 9/27/12, failed to identify the need for the facility to monitor this resident for specific side effects from the resident's Meclizine and Clonazepam. Observation on 10/25/12 at 8:03 A.M. revealed the resident opened the door to his/her room and stood in the doorway. During interview on 10/25/12 at 10:37 A.M. administrative nurse D acknowledged the side effects for the Clonazepam and Meclazine were not care planned. Staff use the application on their phones or the drug book at the nurse's station to see what side effects to monitor for specific medications. The consultant pharmacy did not review care plans for individualized medication side effect monitoring. The consultant pharmacy staff GG failed to identify the facility's lack of monitoring for this resident's medications.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E015	A. BUILDING _____ B. WING _____	10/30/2012

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F 428	Continued From page 57	F 428		

- The Physician's Order Sheet (POS) dated 10/1/12 for resident #21 revealed diagnoses of dementia (memory problems), multifactorial Alzheimer's type (memory problems); ischemic cerebrovascular accident (stroke); diabetes type I (blood sugar problems); atherosclerotic coronary artery disease (build up of deposits in blood vessels); hypertension (high blood pressure); osteoarthritis (sore bone joints), and hyperlipidemia (high fat levels in the blood).

The Quarterly Minimum Data Set (MDS) dated 8/8/12 revealed the resident had long/short term memory problems; was able to recall staff names/faces; had moderately impaired cognitive skills for daily decision making; scored 3 (mild depression) for Mood; and received antipsychotic/antidepressant medications.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The Medication Regimen Review dated 7/19, 8/23, 9/20, 10/18/12 revealed no irregularities.

Staff interview on 10/23/12 at 9:00 A.M. with licensed nursing staff H stated she/he obtained the medication side effects from a nursing drug book located at the nursing station, on her/his phone, or can be looked up on the computer.

Staff interview on 10/23/12 at 9:05 A.M. with direct care staff R stated medication side effects can be obtained from the nurse or the drug book

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 58 located at the nursing station. Attempted interview on 10/29/12 at 1:55 P.M. revealed unable to contact pharmacy consultant for interview. The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary. The consultant pharmacy staff GG failed to identify lack of side effects monitoring for this resident's medications. - The Physician's Order Sheet (POS) dated 10/1/12 for resident #15 revealed diagnoses of hypertension (high blood pressure), hypocalcemia (low calcium in the blood), hyperlipidemia (high fat in the blood), iron deficiency anemia (low iron	F 428		

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F 428	Continued From page 59	F 428		

in the blood), depression (mood disorder), leukocytosis (high white blood cells in the blood), dementia (memory problems), sundowners (mood disorder), and constipation (irregular bowel movement).

The Significant Change Minimum Data Set (MDS) dated 9/26/12 revealed a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment); and received antipsychotic and antidepressant medications.

The clinical record lacked evidence of medication side effects for any of the medications staff gave the resident.

The Medication Regimen Review dated 7/19, 8/23, 9/20, and 10/18/12 revealed no irregularities.

Staff interview on 10/23/12 at 9:00 A.M. with licensed nursing staff H stated she/he obtained the medication side effects from a nursing drug book located at the nursing station, on her/his phone, or can be looked up on the computer.

Staff interview on 10/23/12 at 9:05 A.M. with direct care staff R stated medication side effects can be obtained from the nurse or the drug book located at the nursing station.

Attempted interview on 10/29/12 at 1:55 P.M. revealed unable to contact pharmacy consultant for interview.

The facility-provided policy entitled Monitoring of Medication Side Effects (undated) directed staff to refer to the drug handbook at the nurse's desk

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F 428	Continued From page 60 for monitoring of all medication side effects or the online program Lippincott's Nursing Drug Advisor. Some of the charge nurses had a triage application on their personal phones to look up medication side effects. Staff members would report any unusual symptoms to the charge nurse or long term care supervisor. Facility staff reviewed medication if symptoms arose and notified the practitioner as pertinent. The charge nurse did a monthly nursing summary on each resident. Facility staff used a tickler file to assure the completion of the monthly summary. Staff addressed medication side effects in the summary. The consultant pharmacy staff GG failed to identify lack of side effects monitoring for this resident's medications.	F 428		